Pain & Wellness Group Registration & Health History

1. Patient Information

Today's Date:_____

Patient Legal Name:(Last, First, Middle) _____

_____

Address:_____
Street

_____
City State Zip Code

Sex: ☐ Female ☐ Male Age:_____

Date of Birth:(mm/dd/yyyy) _____/_____/_____

☐ Married ☐ Single ☐ Minor ☐ Divorced

☐ Separated ☐Widowed ☐Partnered for ___yrs.

SSN:_____

Email:_____

Patient Employer/School:_____

Occupation:_____

Employer/School City, State:_____

_____

*Spouse's Name:*_____

Whom/what may we thank for referring you:

☐Family/Friend:_____

☐ Advertisement ☐ Drove-by/Walk-in

☐ Internet Search ☐ Insurance

☐ Other:_____

2. Insurance & HIPPA Information

Please provide your health insurance card(s) for us to copy into your personal file

Primary Insurance: _____

Secondary Insurance:_____

Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Pain & Wellness Group &/or Lexington Pain & Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I further agree to allow this office to examine me for further evaluation.

_____
Signature of Patient/Guardian

_____
Print name of Patient/Guardian

_____
Date Relationship to Patient

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability:_____

3. Phone Numbers

Cell Phone:_(____)_____

Home Phone:_(____)_____

Please circle preferred primary number: Cell or Home?

In case of emergency, contact:

Name:_____ Relationship:_____

Phone Number(s):_____

4. Accident Information

Is condition due to an accident someone/place is responsible for? ☐ Yes ☐ No Date:_____

Type of accident: ☐ Auto ☐ Work ☐Other:_____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp ☐Other

Attorney Name (if applicable)_____

5. Patient Condition

Reason for visit:_____

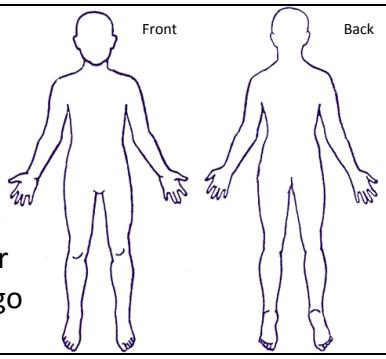
When did symptoms appear? _____

Is condition getting progressively worse? ☐ Yes ☐ No

Severity of pain: 1 (least pain) to 10 (severe pain) _____

Describe: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Shooting ☐Stiffness ☐Other

How often do you have this pain:_____ Is it: ☐Constant *or* ☐Come & go



Patient Name:_____DOB:_____Date:_____

6. Health History

What treatment have you received for this condition in the past? ☐Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other:_____

Date of Last: X-Ray_____ MRI, CT-Scan, Bone Scan_____

Please check "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Pregnancy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	☐Vaginal	☐ Cesarean
Bleeding Disorders	☐ Yes ☐ No	Fatigue	☐ Yes ☐ No	Loss of balance	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Menstrual Pain	☐ Yes ☐ No	Ringing in Ears	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Sleeping Problems	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Other_____	
Dizziness	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	
				Polio	☐ Yes ☐ No	_____	

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Pack/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_____
☐ Vigorous	☐ Heavy Labor	☐ High Stress Level	Reason_____

*Are you pregnant? ☐ Yes ☐ No Due Date_____ Initials_____

Injuries/Surgeries you have had Description Date

Falls_____

Head Injuries_____

Broken Bones_____

Dislocations_____

Surgeries_____

7. Medications	Allergies	Vitamins/Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

(Only for those signing for the patient)